

## Choosing priorities

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*Dr Gray leaves us with a question at the conclusion of his article – how should we choose priorities? He says that the debate so far has been mainly on what we should choose, but perhaps we should consider how to choose even more.*

*Under the various subheadings of Criteria, Principles and Persons Dr Gray sets out the pros and cons of the arguments in the priority debates and tries to offer some more specific guidelines to offset the criticism that the government's priority discussions have been too generalised. Yet this is a difficult task when everyone's priorities are so different.*

It has been suggested that priority debates in the National Health Service are too abstract, and that they would be easier to conduct if they were to be more specific. It is certainly true that to discuss 'hospital or community care', or 'the elderly as a priority', or 'the need for prevention' creates confusion. For example, what is needed most by some elderly people and their relatives is not community care, but hospital care, and not just geriatric and psychogeriatric services. From the regional variation in rates of cataract removal, hip replacement, and pacemaker insertion, it can be deduced that there must be many elderly people who would benefit from such high technology hospital services if they were more widely available than at present. It could also be argued that such services are preventive; they prevent disability and dependence. The use of the same word 'prevention' to cover all aspects of prevention confuses the debate on priorities. Consider the treatment of haemophilia. It is high technology, expensive, medicine, based on some of the highest quality scientific research, yet the objective is preventive; not only the prevention of premature death but the prevention of family breakdown, educational deprivation, and consequent unemployment and poverty. Furthermore, it has been necessary to use the skills and resources invested in hospital-based haemophilia services to their limits to achieve the community care of people with haemophilia. The discussion of priorities has often been too abstract but it has, at the same time, not been abstract enough. Insufficient attention has been given to four important questions. On what criteria should options be compared? On what principles

should the criteria be based? Who should decide on priorities? By what procedure should the decision-makers rank priorities?

### Criteria

The most important criterion should be the effectiveness of the services which are under consideration, but so little is currently known about the effectiveness of many services and treatments that services whose effectiveness has not yet been unequivocally demonstrated have to be considered as well as those in which controlled trials have been employed. In any case, even if we restrict the options to those which have been shown to be effective we should still have to make choices, as they alone could consume more than the additional resources which became available for health service expansion. For example, to make good the short-fall in services for the treatment of people with chronic renal failure could alone consume much of any real increase in resources which might be voted to the health service by Cabinet<sup>1</sup>. In recent years, particularly since Cochrane<sup>2</sup> introduced 'effectiveness and efficiency' into the common currency of our vocabulary in 1972, the economic value of a man's life has become increasingly important. First given prominence by Adam Smith in 1776, valuation was refined in the nineteenth century by the rise of the insurance business and the growth of the profession of actuaries (the Institute of Actuaries was founded in 1848). However, the actuarial approach, which is based on the amount a man is prepared to pay to insure his life, is only one method of valuation which was developed for a particular purpose – the operation of a solvent insurance business<sup>3</sup>. Other methods of valuation can be employed. For example, the value of a man's life can be considered to be a function of the production which would be lost if he were to die, or the implied value of life can be calculated on the basis of decisions taken to introduce measures to prevent premature deaths.<sup>4-7</sup> Having calculated the value of a man's life, the cost of life-saving services can be compared with the benefits which will accrue if lives are saved – the process of cost-benefit analysis.

The strength of cost-benefit analysis, or any other concept, is a function of its weakest point, which is that it attempts to put a monetary value on human

life. Applying the same argument to the cost of disability is equally problematic as the Pearson Committee found.<sup>8</sup> The value of life is not like the value of sheet steel, ball bearings, or any of the other commodities for which cost-benefit analysis is usually employed. It cannot be expressed in monetary terms. Although it is sometimes helpful to use cost-effectiveness as a criterion for comparing different methods of achieving a certain objective, for instance when comparing renal transplantation with haemodialysis<sup>9</sup>, cost-benefit analysis does not provide the decision maker with incontrovertible criteria. The comparison of patients requiring special care baby units with those requiring renal transplantation or with those who require chiropody, or with any other group has to be made on *ethical*, not on financial grounds.

### Principles

The ethical concept which is most relevant to the choosing of priorities is that of distributive justice. Of the many principles applicable to the just distribution of limited resources the principle of utility is the best known. The principle has been an important influence on the British understanding of distributive justice since Jeremy Bentham wrote that 'a measure of Government may be said to be conformable to or dictated by the principle of utility, when . . . the tendency which it has to augment the happiness of the community is greater than any which it has to diminish it.'<sup>11</sup> Important though the influence of Bentham has been the principle of utility is perhaps better known by the term 'utilitarianism' which was introduced to the general public by J S Mill, whose famous essay of that name was published in 1861. Mill's enunciation of the utility principle is that 'the Greatest Happiness Principle holds that actions are right in proportion as they tend to cause happiness, wrong as they tend to produce the reverse of happiness. By happiness is intended pleasure, and the absence of pain, by unhappiness, pain, and the privation of pleasure'.<sup>12</sup> Utilitarianism is an attractive theory, but it poses many problems. One is that it required us to be able to measure 'happiness'. Even if we translate this into 'health', we find that we do not have a measure of health, only measures of illness. Another, more serious problem is that it assumes that the pain suffered by one group of individuals can be offset by the freedom of pain enjoyed by others. This is a serious drawback, most trenchantly enunciated by Ivan Karamazov:

Tell me frankly, I appeal to you – answer me: imagine that it is you yourself who are erecting the edifice of human destiny with the aim of making men happy in the end, of giving them peace and contentment at last, but that to do that it is absolutely necessary, and indeed quite inevitable, to torture

to death only one tiny creature . . . and to found the edifice on her unavenged tears – would you consent to be the architect on those conditions? Tell me and do not lie!<sup>12</sup>

The Pareto Principle, introduced by Pareto in 1909, avoids this injustice by stating that 'group welfare is at an optimum when it is impossible to make any one person better off without at the same time making at least one other person worse off'.<sup>13</sup> This principle saves Ivan Karamazov's hypothetical baby but suggests that the only method by which additional resources can be allocated is in exact proportion to the present pattern of expenditure which justifies the *status quo*; for any course of action is bound to have adverse effects on someone. A number of other principles have been suggested by welfare economists. These are excellently summarised by A K Sen in *Collective Choice and Social Welfare*,<sup>14</sup> but none is faultless; all result in injustice to some party.

Unfortunately it appears that there is no principle which solves the ethical dilemma posed by the need to compare two or more groups of patients. The principles which prevail in society influence decisions but they do not make them. Decisions are made on the basis of the personal values of the decision makers.

### Persons

Personal values are determined by the values of the community and its moral principles, which are modified by each individual in the light of his personal experience. A parent dies of cancer; a relative is mentally ill; a friend dies of renal failure because of shortage of resources – experiences such as these shape the individual's attitudes and his values, as do his professional training and special interests. We are all biased by our experience. No-one approaches a set of options from a completely neutral, 'objective', position and no amount of training can make an individual value-free. However, suitable education can help an individual become aware of his own values, which may lead him to pre-judge a series of options in favour of the one towards which he is biased. As Miller and Gwynne wrote in their methodological section of their classic study of an institute for young disabled people *A Life Apart*:

The problem of becoming personally involved with one's respondents was not, of course, new to us: it is inherent in our method of working. The way we have dealt with this in the past has been to accept that one uses oneself as a measuring instrument, and try to develop means of calibrating it so as to correct some of the distortions.<sup>15</sup>

In the absence of absolute principles on which decisions can be made the key question becomes

'who should choose?' Should the decisions be made by elected representatives of the people? It could be argued that representatives would not be really representative because they have strong political biases, which mean that their personal values are not identical with the 'average citizen', for we must accept that elections to health authorities would very soon become party political contests. Should the decisions be made by people chosen, not because they are representative, but because they have enough insight to see their own biases and therefore be able to compensate for them? It may be that this principle is implicit in the present system of nomination of health authority members, but the system of nomination of wise men and women has come under attack from a number of quarters. Should the professionals decide? Their understanding of the issues is unequalled, but their bias could be too great for them to be representatives of society's collective choice, or even representative of the view of their own profession. Specialisation means that individual technocrats, doctors for example, are perhaps more appropriately cast as delegates of their own special interest groups, rather than decision makers with whom the ultimate authority should lie. The role of the community physician is of particular interest in this context: should he be advocate for the unfashionable, or foreman of the jury, or judge?

One principle which does appear to be helpful in this context is Popper's suggestion that an objective should be to 'design institutions for preventing even bad rulers from doing too much damage.'<sup>16</sup> Rather than trying to choose the 'best' decision makers and striving to create the 'best possible' system in which such philosopher-kings operate, we should concentrate our energies on designing a system in which the effects of bad decision-making can be minimised.

## Voting

By whatever process the decision makers are selected the method by which their individual decisions are transmuted into a group decision also has to be considered. Should a simple majority be taken as expressing the wish of the group, or does that only lead to what Mill called the tyranny of the majority? Should priorities be ranked and given transferable votes, as is used in proportional representation? This is attractive, but it can lead to

situations in which the expressed priorities of the group are very different from the priorities of each individual member.<sup>13</sup> Has government by consensus led to inertia? The choice of voting procedure is an important issue, but less important than issues concerning the principles on which priorities should be compared, and the selection of people who should decide.

## Conclusion

In the priorities debate so far, the emphasis has been on what should be chosen.<sup>17</sup> Perhaps the highest priority is to decide how we should choose.

## References

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